FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043596

Facility Name: Magnolia Wood Health Care Center

Address: 900 North Market Street (Number) Watseka (City) 60970 (Zip Code)

County: Iroquois

Telephone Number: (815) 432-5261 **Fax #** (815) 432-5268

IDPA ID Number: 830320180003

Date of Initial License for Current Owners: 2/7/1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317)566-1586

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) William H. Keys

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Chris Murphy, CPA, Partner

(Firm Name & Address) BKD, LLP, 6120 S. Yale, Suite 1400

(Telephone) (918) 584-2900 Fax # (918) 584-2931

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,655	2,635	1,930	12,220	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,655	2,635	1,930	12,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.93%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 76 and days of care provided 1,930

Medicare Intermediary Trailblazer Health Enterprises, L.L.C.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	74,808	6,261	3,540	84,609		84,609		84,609			1
2	Food Purchase		46,181		46,181		46,181	(586)	45,595			2
3	Housekeeping	36,915	5,458	710	43,083		43,083		43,083			3
4	Laundry	38,647	4,930		43,577		43,577	(137)	43,440			4
5	Heat and Other Utilities			48,536	48,536		48,536	(2,459)	46,077			5
6	Maintenance	31,934	4,175	16,960	53,069		53,069	857	53,926			6
7	Other (specify):* Waste Removal			3,937	3,937		3,937		3,937			7
8	**TOTAL General Services**	182,304	67,005	73,683	322,992		322,992	(2,325)	320,667			8
	B. Health Care and Programs											
9	Medical Director			5,070	5,070		5,070		5,070			9
10	Nursing and Medical Records	450,510	56,993	154,744	662,247		662,247	3	662,250			10
10a	Therapy		243	126,234	126,477		126,477		126,477			10a
11	Activities	21,713	838	2,675	25,226		25,226		25,226			11
12	Social Services	15,045		2,674	17,719		17,719		17,719			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Non allow cost											15
16	**TOTAL Health Care and Programs**	487,268	58,074	291,397	836,739		836,739	3	836,742			16
	C. General Administration											
17	Administrative	22,515		47,486	70,001		70,001		70,001			17
18	Directors Fees											18
19	Professional Services			24,338	24,338		24,338	9,856	34,194			19
20	Dues, Fees, Subscriptions & Promotions			43,428	43,428		43,428	(5,871)	37,557			20
21	Clerical & General Office Expenses	56,342	10,837	21,168	88,347		88,347	112,614	200,961			21
22	Employee Benefits & Payroll Taxes			147,382	147,382		147,382		147,382			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,864	12,864		12,864	1,956	14,820			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			60,111	60,111		60,111	14	60,125			26
27	Other (specify):*											27
28	**TOTAL General Administration**	78,857	10,837	356,777	446,471		446,471	118,569	565,040			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	748,429	135,916	721,857	1,606,202		1,606,202	116,247	1,722,449			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Magnolia Wood Health Care Center #0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			45,130	45,130		45,130	260	45,390			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							2	2			32
33	Real Estate Taxes			28,817	28,817		28,817	19	28,836			33
34	Rent-Facility & Grounds							1,026	1,026			34
35	Rent-Equipment & Vehicles			8,193	8,193		8,193	104	8,297			35
36	Other (specify):* **See Attached**			163	163		163		163			36
37	**TOTAL Ownership**			82,303	82,303		82,303	1,411	83,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,889	1,625	52,514		52,514		52,514			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,724	41,724		41,724		41,724			42
43	Other (specify):* **Lab & Rad**											43
44	**TOTAL Special Cost Centers**		50,889	43,349	94,238		94,238		94,238			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	748,429	186,805	847,509	1,782,743		1,782,743	117,658	1,900,401			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(415)	02		4
5	Telephone, TV & Radio in Resident Rooms	(2,459)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(171)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,875)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(99)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,971)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Revenue				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (13,990)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	131,648	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 131,648		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 117,658		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Magnolia Wood Health Care Center

ID# **0043596**

Report Period Beginning: **1/1/2004**

Ending: **12/31/2004**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other-Attach Schedule - Goodwill	$ 0		1
2	Other-Attach Schedule - Other non allowable exp	0		2
3	Other-Attach Schedule - Vending revenue	0		3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Magnolia Wood Health Care Center **#** 0043596 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(586)	0	0	0	0	0	0	0	0	0	0	(586)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(137)	0	0	0	0	0	0	0	0	0	(137)	4
5	Heat and Other Utilities	(2,459)	0	0	0	0	0	0	0	0	0	0	(2,459)	5
6	Maintenance	0	857	0	0	0	0	0	0	0	0	0	857	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,045)	720	0	0	0	0	0	0	0	0	0	(2,325)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3	0	0	0	0	0	0	0	0	0	3	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	3	0	0	0	0	0	0	0	0	0	3	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(99)	9,955	0	0	0	0	0	0	0	0	0	9,856	19
20	Fees, Subscriptions & Promotions	(5,971)	100	0	0	0	0	0	0	0	0	0	(5,871)	20
21	Clerical & General Office Expenses	(4,875)	117,489	0	0	0	0	0	0	0	0	0	112,614	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,956	0	0	0	0	0	0	0	0	1,956	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	14	0	0	0	0	0	0	0	0	14	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,945)	127,544	1,970	0	0	0	0	0	0	0	0	118,569	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,990)	128,267	1,970	0	0	0	0	0	0	0	0	116,247	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	260	0	0	0	0	0	0	0	0	260	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2	0	0	0	0	0	0	0	0	2	32
33	Real Estate Taxes	0	0	19	0	0	0	0	0	0	0	0	19	33
34	Rent-Facility & Grounds	0	0	1,026	0	0	0	0	0	0	0	0	1,026	34
35	Rent-Equipment & Vehicles	0	0	104	0	0	0	0	0	0	0	0	104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	1,411	0	0	0	0	0	0	0	0	1,411	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(13,990)	128,267	3,381	0	0	0	0	0	0	0	0	117,658	45

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Organizational Structure						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	(137)	(137)	4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	0		5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	857	857	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	3	3	8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	0		10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	9,955	9,955	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	100	100	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	117,489	117,489	13
14	Total			$			$ 128,267	$ * 128,267	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	Employee Benefits & Payroll Taxes	$	Senior Living Properties	100.00%	$ 0	$	15
16	V		24	Travel and Seminar		Senior Living Properties	100.00%	1,956	1,956	16
17	V		26	Insurance - Prop Liab Malpractice		Senior Living Properties	100.00%	14	14	17
18	V		30	Depreciation		Senior Living Properties	100.00%	260	260	18
19	V		32	Interest		Senior Living Properties	100.00%	2	2	19
20	V		33	Real Estate Taxes		Senior Living Properties	100.00%	19	19	20
21	V		34	Rent - Facility & Grounds		Senior Living Properties	100.00%	1,026	1,026	21
22	V		35	Rent - Equipment & Vehicles		Senior Living Properties	100.00%	104	104	22
23	V		36	Loss, Goodwill, & Depreciation		Senior Living Properties	100.00%	0		23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 3,381	$ * 3,381	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12900 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317)566-1586
Fax Number: (317) 581-9513

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See Attachment	See Attachment	See Attachment	$ 0	$	See Attachment	$ 0	1
2	2	Food Purchase	See Attachment	See Attachment	See Attachment	0		See Attachment	0	2
3	3	Housekeeping	See Attachment	See Attachment	See Attachment	0		See Attachment	0	3
4	4	Laundry	See Attachment	See Attachment	See Attachment	(14,096)		See Attachment	(137)	4
5	5	Heat and Other Utilities	See Attachment	See Attachment	See Attachment	0		See Attachment	0	5
6	6	Maintenance	See Attachment	See Attachment	See Attachment	95,381		See Attachment	857	6
7	7	Waste Removal	See Attachment	See Attachment	See Attachment	0		See Attachment	0	7
8	10	Nursing & Medical Records	See Attachment	See Attachment	See Attachment	267		See Attachment	3	8
9	10a	Therapy	See Attachment	See Attachment	See Attachment	0		See Attachment	0	9
10	17	Administrative	See Attachment	See Attachment	See Attachment	0		See Attachment	0	10
11	19	Professional Services	See Attachment	See Attachment	See Attachment	1,026,001		See Attachment	9,955	11
12	20	Dues, Fees, Subscriptions & Prom	See Attachment	See Attachment	See Attachment	10,855		See Attachment	100	12
13	21	Clerical & General Office Expens	See Attachment	See Attachment	See Attachment	12,021,375		See Attachment	117,489	13
14	22	Employee Benefits & Payroll Taxe	See Attachment	See Attachment	See Attachment	0		See Attachment	0	14
15	24	Travel and Seminar	See Attachment	See Attachment	See Attachment	272,954		See Attachment	1,956	15
16	26	Insurance - Prop Liab Malpractic	See Attachment	See Attachment	See Attachment	1,435		See Attachment	14	16
17	30	Depreciation	See Attachment	See Attachment	See Attachment	26,841		See Attachment	260	17
18	32	Interest	See Attachment	See Attachment	See Attachment	249		See Attachment	2	18
19	33	Real Estate Taxes	See Attachment	See Attachment	See Attachment	1,914		See Attachment	19	19
20	34	Rent-Facility & Grounds	See Attachment	See Attachment	See Attachment	105,820		See Attachment	1,026	20
21	35	Rent-Equipment & Vehicles	See Attachment	See Attachment	See Attachment	10,725		See Attachment	104	21
22	36	Loss, Goodwill, & Depreciation	See Attachment	See Attachment	See Attachment	0		See Attachment	0	22
23										23
24										24
25	TOTALS					$ 13,559,723	$		$ 131,648	25

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	26,383	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,383	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	28,817	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	28,817	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	25,500	8
	2000	22,752	9
	2001	26,431	10
	2002	26,941	11
	2003	28,114	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Magnolia Wood Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0043596

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317)566-1586 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-C-19-31-227-003	See Attached	$ 28,113.84	$ 28,113.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,113.84	$ 28,113.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,089 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	98,881	1998	$ 21,462	1
2					2
3	TOTALS	98,881		$ 21,462	3

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1998	1969	$ 805,098	$ 26,837	30	$ 26,837	$	$ 185,620	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	interior			1998	41		5			41	9
10	paint			1998	104		5			104	10
11	carpet admin-O			1998	360		5			360	11
12	install tile			1998	650	65	10	65		396	12
13	carpet admin-O			1998	895		5			895	13
14	painting labor			1998	1,386		5			1,386	14
15	painting labor			1998	1,500		5			1,500	15
16	steel door install			1998	1,804	90	20	90		571	16
17	alarm system			1998	2,581	258	10	258		1,635	17
18	install fire alarm			1998	2,873	287	10	287		1,772	18
19	painting labor			1998	2,893		5			2,893	19
20	tile & cov base			1998	5,593	280	20	280		1,725	20
21	Big border, small border			1998	137		5			137	21
22	Over-bed lights			1998	1,527	76	20	76		471	22
23	Washer, moulding, lumber			1998	41		5			41	23
24	paint-borders			1999	469	8	5	8		469	24
25	roof to cover patio			1999	3,071	307	10	307		1,817	25
26	paint trim			1999	524	9	5	9		524	26
27	painting labor			1999	304	10	5	10		304	27
28	install tile			1999	1,109	55	20	55		323	28
29	shutters			1999	600	40	15	40		233	29
30	nurses call battery backup			1999	1,177	118	10	118		677	30
31	light fixtures			1999	1,390	139	10	139		799	31
32	Carpeting			1999	221	37	5	37		221	32
33	Cove base/floor tile			1999	1,390	139	10	139		799	33
34	Natural Gas Water Heater			2001	2,585	259	10	259		819	34
35	Build. Maint. For Sprinkler System			2004	1,509	35	25	35		35	35
36	4 Fire dampers			2002	2,749	183	15	183		397	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Motorized fire and smoke dampers		$ 1,125	$ 112	10	$ 112	$	$ 262	37
38	Water Heater	2001	2,464	164	15	164		657	38
39	Privacy Leverset	2001	522	65	8	65		223	39
40	Phone Hook Up	2001	505	101	5	101		336	40
41	13 smoke detectors	2002	1,980	198	10	198		429	41
42	Steel Smoke Door	2002	1,762	118	15	118		255	42
43	Land Improvement	1998	8,956	597	15	597		4,130	43
44	Signage	1998	464	46	10	46		305	44
45	Pave parking lot	1999	6,684	334	20	334		2,005	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 869,043	$ 30,967		$ 30,967	$	$ 215,566	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 114,894	$ 13,742	$ 13,742	$	Various	$ 96,337	71
72	Current Year Purchases	13,251	421	421		Various	421	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 128,145	$ 14,163	$ 14,163	$		$ 96,757	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,018,650	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,130	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,130	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 312,323	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 8,193 Description: Nursing - 158, Central Supply - 160, Dietary - 441, Plant - 30, Housekeeping - 1,642, Administrative - 5,762
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	1,068	$ 34,293	$ 17	1,068	$ 34,310	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		171	5,492	0	171	5,492	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,691	86,449	227	2,691	86,676	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,930	$ 126,234	$ 243	3,930	$ 126,478	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (30,631)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	393,911		3
4	Supply Inventory (priced at)	10,793		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 374,073	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,462		13
14	Buildings, at Historical Cost	855,497		14
15	Leasehold Improvements, at Historical Cost	16,103		15
16	Equipment, at Historical Cost	125,587		16
17	Accumulated Depreciation (book methods)	(312,323)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Intercompany			22
23	Other(specify): Intercompany (Pay)/Rec	(3,391,581)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (2,685,255)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (2,311,182)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 18,012	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,688		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,236		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,817		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 80,753	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 80,753	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,391,935)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,311,182)	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,421,709)	1
2	Restatements (describe):		2
3	**Accounting Adjustments**	250,047	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,171,662)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(220,273)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (220,273)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,391,935)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,948,093	1
2	Discounts and Allowances for all Levels	(789,844)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,158,249	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	205,764	6
7	Oxygen	34,135	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 239,899	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	101	13
14	Non-Patient Meals	415	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,707	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,581	19
20	Radiology and X-Ray	15,034	20
21	Other Medical Services	28,008	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 161,846	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,476	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,476	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending		28
28a	Vending		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,562,470	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	322,992	31
32	Health Care	836,739	32
33	General Administration	446,471	33
	B. Capital Expense		
34	Ownership	82,303	34
	C. Ancillary Expense		
35	Special Cost Centers	52,514	35
36	Provider Participation Fee	41,724	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,782,743	40
41	**Income before Income Taxes (line 30 minus line 40)****	(220,273)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (220,273)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	0	0	$ 0	$	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	2,998	3,242	69,645	21.48	3
4	Licensed Practical Nurses	8,670	9,589	193,984	20.23	4
5	Nurse Aides & Orderlies	19,616	20,680	186,881	9.04	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,836	2,008	20,621	10.27	9
10	Activity Assistants	152	158	1,092	6.91	10
11	Social Service Workers	924	943	15,045	15.95	11
12	Dietician	1,850	1,929	25,167	13.05	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	6,409	6,769	49,641	7.33	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,305	2,411	31,934	13.25	17
18	Housekeepers	5,202	5,485	36,915	6.73	18
19	Laundry	3,856	4,338	38,647	8.91	19
20	Administrator	617	617	22,515	36.49	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,329	4,475	56,342	12.59	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	58,764	62,644	$ 748,429 *	$ 11.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 3,540	1, 3	35
36	Medical Director	96	5,070	9, 3	36
37	Medical Records Consultant			10, 3	37
38	Nurse Consultant			10, 3	38
39	Pharmacist Consultant	96	1,797	10, 3	39
40	Physical Therapy Consultant			10a, 3	40
41	Occupational Therapy Consultant			10a, 3	41
42	Respiratory Therapy Consultant			10a, 3	42
43	Speech Therapy Consultant			10a, 3	43
44	Activity Consultant	48	2,675	11, 3	44
45	Social Service Consultant	48	2,674	12, 3	45
46	Other(specify) Administrative Consu	2,080	46,789	17,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,464	$ 62,545		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,080	$ 78,987	10,3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,080	$ 78,987		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Contract Services: Administrator	$ 46,789
Misc. Fees	697
TOTAL (agree to Schedule V, line 17, col. 3)	$ 47,486
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 99
Patient Litigation	Various	0
Payroll Processing	Various	3,332
Accounting	Various	7,120
EDP Services	Various	13,787
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,338

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,565
Unemployment Compensation Insurance	0
FICA Taxes	94,575
Employee Health Insurance	(8)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,250
TOTAL (agree to Schedule V, line 22, col.8)	$ 147,382

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,598
Health Care Worker Background Check	1,303
(Indicate # of checks performed 32)	
Dues & Subscriptions	29,456
Advertising & Public Relations	5,971
Home Office Allocation	100
Less: Public Relations Expense	( )
Non-allowable advertising	(5,871)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,557

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,100
Seminar Expense	593
Business Meals	171
Home Office Allocation	1,956
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,820

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Magnolia Wood Health Care Center # 0043596 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **0 N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,100** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility. IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,724**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **415**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees